CDC

MMWR™

Morbidity and Mortality Weekly Report

Weekly February 20, 2004 / Vol. 53 / No. 6

American Heart Month — February 2004

February is American Heart Month. Heart disease is the leading cause of death in the United States and a major cause of permanent disability. During 2004, of the estimated 1.2 million persons who will have a heart attack, approximately half will die (*1*). Recognizing and responding promptly to heart attack symptoms and receiving appropriate care can prevent or limit heart damage (*2*).

In 2001, approximately 17% of U.S. residents who died from heart disease were aged <65 years; the percentage was higher among blacks, American Indians/Alaska Natives, Asians/Pacific Islanders, and Hispanics. Reducing racial/ethnic disparities in the percentage of deaths from heart disease among persons aged <65 years will require programs to detect and prevent the major risk factors for heart disease among young and middle-aged adults.

CDC funds health departments in 32 states and the District of Columbia to develop programs for reducing the burden of heart disease and stroke and their risk factors. These programs emphasize multiple strategies to target heart disease and stroke in various settings and to ensure that patients receive quality care. Additional information about CDC's State Heart Disease and Stroke Prevention Program is available at http://www.cdc.gov/cvh/stateprogram.htm.

References

1. American Heart Association. Heart disease and stroke statistics—2004 update. Dallas, Texas: American Heart Association, 2003. Available at http://www.americanheart.org/presenter.jhtml?identifier=1200026.
2. Ornato JP, Hand MM. Warning signs of a heart attack. Circulation 2001;104:1212–3.

Disparities in Premature Deaths from Heart Disease — 50 States and the District of Columbia, 2001

In 2001, heart disease accounted for approximately 29.0% of deaths among U.S. residents; 16.8% of those deaths occurred among persons aged <65 years (*1*). Although mortality rates from heart disease have decreased, the decline has not been uniform for all populations (*2*). One of the two overall national health objectives for 2010 is to eliminate health disparities among different segments of the U.S. population (*3*). To better understand these disparities, CDC analyzed death certificate data for premature deaths from heart disease occurring in 2001. This report summarizes the results of that analysis, which indicated that the proportion of premature heart disease deaths varied by state and was higher among blacks, American Indians/Alaska Natives (AI/ANs), Asians/Pacific Islanders (A/PIs), and Hispanics. Reducing premature death from heart disease and eliminating disparities will require preventing, detecting, treating, and controlling risk factors for heart disease in young and middle-aged adults.

Death certificate data from the 50 states and the District of Columbia (DC) were obtained from the National Center for Health Statistics. Demographic data (e.g., age and race/ethnicity) on death certificates were reported by funeral directors or provided by family members. Heart disease–related deaths were defined as those for which the underlying

INSIDE

125 Heterosexual Transmission of HIV — 29 States, 1999–2002
129 Using the Internet for Partner Notification of Sexually Transmitted Diseases — Los Angeles County, California, 2003
131 Fatal Case of Unsuspected Pertussis Diagnosed from a Blood Culture — Minnesota, 2003
133 Notice to Readers

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2004;53:[inclusive page numbers].

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causes listed on death certificates by a physician or coroner were *International Classification of Diseases, Tenth Revision* (ICD-10), codes I00–I09, I11, I13, or I20–I51. Premature deaths were defined as those occurring among persons aged <65 years. Proportions of premature death were calculated for all 50 states and DC.

During 2001, of 700,142 deaths attributed to heart disease, 117,346 (16.8%) occurred among persons aged <65 years. The proportion of premature deaths was greatest among AI/ANs (36.0%) and blacks (31.5%) and lowest among whites (14.7%) (Table 1). Premature death was higher for Hispanics (23.5%) than non-Hispanics (16.5%), and for males (24.0%) than females (10.0%). Hispanic whites (23.3%) had lower proportions than Hispanic blacks (27.5%), and non-Hispanic whites had lower proportions (14.4%) than non-Hispanic blacks (31.5%). The highest proportions of all deaths occurred among persons aged 55–64 years. When premature death was examined by age-specific death rate, mortality increased with age, and rates across all age groups were highest among blacks and lowest among A/PIs (Figure).

The proportions of premature heart disease deaths ranged from 12.4% in Rhode Island to 35.7% in Alaska (Table 2). The 10 areas with the highest proportions were Alaska (35.7%), Nevada (25.4%), Georgia (23.9%), South Carolina (23.8%), Louisiana (22.9%), DC (21.5%), Alabama (21.4%), Tennessee (21.3%), Mississippi (20.7%), and Texas (20.5%). Among males, proportions were highest in Alaska (41.8%) and lowest in North Dakota (18.6%); among females, proportions were highest in Alaska (26.0%) and lowest in South Dakota (6.3%). Within states/areas, racial/ethnic differences in premature death were similar to those observed overall.

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Editorial Note: In 2001, approximately 17% of all deaths from heart disease occurred among persons aged <65 years; these deaths occurred disproportionately among certain racial/ethnic minority populations, and demographic and geographic disparities also persisted. The determinants of these disparities are not clear. Differences by sex might be attributed in part to the cardioprotective effects of estrogen in pre- and perimenopausal women (*4*). Specific racial/ethnic variations might reflect differences in demographics, risk factors for heart disease, access to medical and emergency care, or other factors. For example, in the United States, the prevalence of obesity and diabetes is higher for blacks and AI/ANs than whites (5). The prevalence of cigarette smoking for AI/ANs is nearly double that for whites (5). Blacks have a higher prevalence of

TABLE 1. Total number of deaths and number and percentage of premature* heart disease deaths, by selected characteristics — 50 states and the District of Columbia, 2001

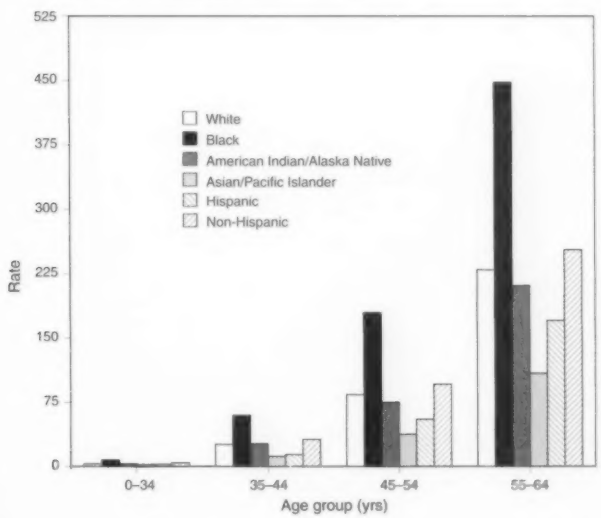
Characteristic	Total no. deaths from heart disease	Premature deaths					
				Age group (yrs)			
		No.	(%)	0–34	35–44	45–54	55–64
Male	339,095	81,362	(24.0)	0.9%	2.8%	7.8%	12.5%
Female	361,047	35,984	(10.0)	0.5%	1.1%	2.8%	5.5%
Race/Ethnicity							
White	610,638	90,066	(14.7)	0.6%	1.6%	4.5%	8.1%
Black	77,674	24,427	(31.5)	2.0%	4.4%	10.4%	14.6%
American Indian/Alaska Native	2,402	865	(36.0)	2.2%	5.2%	11.2%	17.3%
Asian/Pacific Islander	9,428	1,988	(21.1)	1.4%	2.5%	6.5%	10.6%
Hispanic	27,090	6,353	(23.5)	2.1%	2.8%	6.9%	11.6%
White	26,520	6,186	(23.3)	2.1%	2.8%	6.9%	11.6%
Black	426	117	(27.5)	2.1%	2.1%	8.9%	14.3%
Non-Hispanic	673,052	110,993	(16.5)	0.7%	1.9%	5.1%	8.8%
White	584,118	83,880	(14.4)	0.5%	1.5%	4.4%	8.0%
Black	77,248	24,310	(31.5)	2.0%	4.5%	10.4%	14.6%
Total	**700,142**	**117,346**	**(16.8)**	**0.7%**	**1.9%**	**5.2%**	**8.9%**

* Defined as deaths of persons aged <65 years.

high blood pressure than whites (*5–7*), and Hispanics are less likely than whites to have their blood pressure checked (*6*), to be aware of having high blood pressure (*7*), or to be treated and controlled for high blood pressure (*7*). In the United States, greater proportions of blacks, Hispanics, and AI/ANs than whites lack health-care coverage and cite cost as a barrier to obtaining health care (*5*).

State variations probably reflect differences in demographics, lifestyles, and risk factors. Among the 10 areas with the highest proportions of premature death, those in the southeast also have high prevalence of high blood pressure (*6*), smoking, physical inactivity, and obesity (*8*). These risk factors are not as prevalent in DC and Hawaii, which suggests that other risk factors (e.g., dietary factors and elevated serum cholesterol) might be more dominant causes of premature death in those areas.

FIGURE. Heart disease death rates* among persons aged <65 years, by race/ethnicity and age group — 50 states and the District of Columbia, 2001



* Per 100,000 population.

The findings in this report are subject to at least two limitations. First, underlying cause of death data are subject to errors in the certification of cause of death. Second, racial/ethnic populations have different proportions of persons at younger ages (*9*), which might account for the different proportions of premature deaths. In 2001, approximately 86% of non-Hispanic whites were aged <65 years, compared with 92% of non-Hispanic blacks, 94% of AI/ANs, 92% of A/PIs, and 95% of Hispanics (*1*). Although death rates vary by race/ethnicity, heart disease is the leading cause of death for all racial/ethnic minority populations except A/PIs, for which it is the second leading cause of death (*9*).

Risk factors for heart disease include high blood pressure, elevated serum cholesterol levels, smoking, diabetes, physical inactivity, and obesity. Premature death from heart disease can be reduced by preventing or treating these risk factors. Public health professionals should focus efforts on prevention and risk reduction at all ages, and particularly at younger ages among racial/ethnic minorities. Further analysis of state data should be conducted to identify county-level disparities, which might aid public health agencies in allocating resources more effectively. The proportion of deaths among persons aged <65 years and the high prevalence of the major risk factors in the general population underscore the need for aggressive public

TABLE 2. Total number of deaths and number and percentage of premature* heart disease deaths, by area and sex — 50 states and the District of Columbia, 2001

Area	Total no. deaths from heart disease	Premature deaths					
				Male		Female	
		No.	(%)	No.	(%)	No.	(%)
Alabama	13,207	2,826	(21.4)	1,892	(29.7)	934	(13.7)
Alaska	603	215	(35.7)	154	(41.8)	61	(26.0)
Arizona	10,588	1,819	(17.2)	1,295	(22.9)	524	(10.6)
Arkansas	8,263	1,550	(18.8)	1,078	(26.8)	472	(11.1)
California	68,234	10,092	(14.8)	7,133	(21.4)	2,959	(8.5)
Colorado	6,293	1,138	(18.1)	813	(25.9)	325	(10.3)
Connecticut	8,582	1,226	(14.3)	851	(21.2)	375	(8.2)
Delaware	2,033	355	(17.5)	240	(24.5)	115	(10.9)
District of Columbia	1,761	378	(21.5)	244	(30.3)	134	(14.0)
Florida	50,629	6,939	(13.7)	4,908	(19.3)	2,031	(8.1)
Georgia	17,478	4,170	(23.9)	2,809	(33.1)	1,361	(15.2)
Hawaii	2,310	464	(20.1)	305	(23.3)	159	(15.9)
Idaho	2,489	411	(16.5)	294	(22.2)	117	(10.1)
Illinois	30,990	5,518	(17.8)	3,752	(25.8)	1,766	(10.8)
Indiana	15,682	2,779	(17.7)	1,932	(25.3)	847	(10.5)
Iowa	8,250	1,064	(12.9)	749	(19.1)	315	(7.3)
Kansas	6,716	939	(14.0)	650	(20.7)	289	(8.1)
Kentucky	11,808	2,401	(20.3)	1,678	(29.3)	723	(11.9)
Louisiana	11,474	2,628	(22.9)	1,762	(31.1)	866	(14.9)
Maine	3,272	483	(14.8)	342	(22.2)	141	(8.2)
Maryland	12,310	2,395	(19.5)	1,594	(26.9)	801	(12.6)
Massachusetts	15,144	2,008	(13.3)	1,421	(20.4)	587	(7.2)
Michigan	26,896	4,656	(17.3)	3,169	(24.4)	1,487	(10.7)
Minnesota	8,760	1,318	(15.0)	975	(21.6)	343	(8.1)
Mississippi	9,050	1,876	(20.7)	1,190	(29.3)	686	(13.8)
Missouri	16,633	2,665	(16.0)	1,833	(23.4)	832	(9.4)
Montana	1,970	324	(16.4)	234	(22.4)	90	(9.7)
Nebraska	4,150	531	(12.8)	385	(19.9)	146	(6.6)
Nevada	4,393	1,116	(25.4)	832	(33.0)	284	(15.2)
New Hampshire	2,835	407	(14.4)	314	(22.5)	93	(6.5)
New Jersey	22,704	3,009	(13.3)	2,147	(20.5)	862	(7.1)
New Mexico	3,423	588	(17.2)	425	(23.5)	163	(10.1)
New York	56,643	7,523	(13.3)	5,120	(20.1)	2,403	(7.7)
North Carolina	18,792	3,803	(20.2)	2,646	(28.4)	1,157	(12.2)
North Dakota	1,700	226	(13.3)	165	(18.6)	61	(7.5)
Ohio	32,453	5,401	(16.6)	3,728	(24.0)	1,673	(9.9)
Oklahoma	10,840	1,913	(17.6)	1,296	(24.8)	617	(11.0)
Oregon	7,075	1,053	(14.9)	749	(20.7)	304	(8.8)
Pennsylvania	39,438	5,355	(13.6)	3,737	(20.2)	1,618	(7.7)
Rhode Island	3,076	382	(12.4)	266	(19.3)	116	(6.8)
South Carolina	9,471	2,256	(23.8)	1,596	(33.0)	660	(14.3)
South Dakota	1,985	274	(13.8)	214	(20.6)	60	(6.3)
Tennessee	15,688	3,349	(21.3)	2,243	(29.7)	1,106	(13.6)
Texas	43,199	8,873	(20.5)	6,085	(28.3)	2,788	(12.9)
Utah	2,896	480	(16.6)	350	(24.1)	130	(9.0)
Vermont	1,429	189	(13.2)	131	(18.8)	58	(7.9)
Virginia	14,913	2,997	(20.1)	2,053	(28.4)	944	(12.3)
Washington	11,281	1,838	(16.3)	1,320	(22.8)	518	(9.4)
West Virginia	6,325	1,104	(17.5)	768	(25.4)	336	(10.2)
Wisconsin	13,023	1,853	(14.2)	1,364	(21.1)	489	(7.4)
Wyoming	985	189	(19.2)	131	(26.3)	58	(11.9)
Total	**700,142**	**117,346**	**(16.8)**	**81,362**	**(24.0)**	**35,984**	**(10.0)**

*Defined as deaths of persons aged <65 years.

health efforts. Improved health promotion and primary and secondary prevention strategies are needed to decrease the burden of heart disease and eliminate health disparities in the population.

References

1. Arias E, Anderson RN, Hsiang-Ching K, Murphy SL, Kochanek KD. Deaths: final data for 2001. Hyattsville, Maryland: U.S. Department of Health and Human Services, 2003; Natl Vital Stat Rep 2003;52(3).
2. Cooper R, Cutler J, Desvigne-Nickens P, et al. Trends and disparities in coronary heart disease, stroke, and other cardiovascular diseases in the United States: findings of the National Conference on Cardiovascular Disease Prevention. Circulation 2000;102:3137–47.
3. U.S. Department of Health and Human Services. Healthy People 2010, 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.
4. Mendelsohn ME, Karas RH. The protective effects of estrogen on the cardiovascular system. N Engl J Med 1999;340:1801–11.
5. CDC. State-specific prevalence of selected health behaviors, by race and ethnicity—Behavioral Risk Factor Surveillance System, 1997. In: CDC Surveillance Summaries (March 24). MMWR 2000;49(No. SS-2).
6. CDC. State-specific trends in self-reported blood pressure screening and high blood pressure—United States, 1991–1999. MMWR 2002;51: 456–60.
7. Hajjar I, Kotchen TA. Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000. JAMA 2003;290:199–206.
8. CDC. The burden of chronic diseases and their risk factors: national and state perspectives 2002. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2002. Available at http://www.cdc.gov/nccdphp/burdenbook2002/index.htm.
9. Freid VM, Prager K, MacKay AP, Xia H. Chartbook on trends in the health of Americans. Health, United States, 2003. Hyattsville, Maryland: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics, 2003.

Heterosexual Transmission of HIV — 29 States, 1999–2002

Worldwide, the majority of human immunodeficiency virus (HIV) infections result from heterosexual transmission (*1*). To characterize heterosexual transmission of HIV infections in the United States, CDC analyzed data for 1999–2002 from the 29 states* that have met CDC standards (*2*) for name-based HIV/acquired immunodeficiency syndrome (AIDS) reporting for ≥4 years†. This report summarizes the results of that analysis, which indicated that heterosexually acquired HIV infections represented 35% of all new HIV cases; 64% of heterosexually acquired HIV infections occurred in females, and 74% occurred in non-Hispanic blacks. To decrease the number of new heterosexually acquired HIV infections, especially among certain minority populations, culturally targeted education and prevention programs should be provided, and barriers to HIV care and prevention services should be removed.

The analysis included persons aged ≥13 years with HIV; infections were categorized as either heterosexually acquired§ or nonheterosexually acquired. Heterosexually acquired HIV infections were further categorized as diagnosed with AIDS (i.e., during the same calendar month) or diagnosed without AIDS. New diagnoses of HIV infections were examined for 1999–2002. Data were adjusted for reporting delays, and HIV-exposure data were adjusted for reclassification of cases initially reported with no mode of exposure into categories according to historical patterns of reclassification (*3*). CDC calculated confidence intervals (CIs), taking into account adjustments for reporting delays and reclassification to exposure categories, and variance estimates were derived from monthly data submissions to CDC (*4*).

During 1999–2002, a total of 101,877 HIV infections were diagnosed in the 29 states and reported to CDC, including 36,084 (35%) acquired through heterosexual contact (Table). Among states, the median prevalence of heterosexually acquired HIV infections was 27% (range: 13%–47%).

The proportion of females was greater among persons with heterosexually acquired HIV infections (64%; 23,205 of 36,084) than the proportion of females among persons exposed through injection-drug use, blood products, transfusions, and undetermined modes of exposure (36%; 6,661 of 18,732). Among age groups, prevalence for heterosexually acquired HIV infections was greatest (35%) among persons aged 30–39 years.

Non-Hispanic blacks accounted for 26,748 (74%) of persons with heterosexually acquired HIV infections. A total of 5,257 (15%) were non-Hispanic white; 3,498 (10%) were Hispanic; and <1% were Asian/Pacific Islander or American Indian/Alaska Native. By comparison, among persons with nonheterosexually acquired HIV infections, non-Hispanic blacks accounted for 29,607 (45%), and non-Hispanic whites accounted for 26,731 (41%). During 1999–2002, an overall increase in heterosexually acquired HIV infections from 8,925

* Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

† Five additional states (Alaska, Georgia, Kansas, New York, and Texas) have implemented name-based HIV/AIDS reporting that meets CDC standards. Pennsylvania also has implemented such reporting, but only in areas outside Philadelphia.

§ An HIV infection was categorized as heterosexually acquired if a patient reported specific heterosexual contact with a person with HIV infection or with a person at increased risk for HIV infection (e.g., an injection-drug user).

(95% CI = 8,606–9,243) in 1999 to 9,156 (95% CI = 8,713–9,600) in 2002 was not statistically significant.

Among the 36,084 persons with heterosexually acquired HIV infections, 7,395 (20%) (Table) received a concurrent diagnosis of AIDS. Diagnosis of HIV/AIDS was more common among males (25%; 3,223 of 12,879) than among females (18%; 4,172 of 23,205).

Females accounted for 89% of heterosexually acquired HIV infections among persons aged 13–19 years (Figure 1). Females also accounted for 70% of such cases reported among non-Hispanic whites, 64% among non-Hispanic blacks, and 56% among Hispanics (Figure 2).

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Editorial Note: During 1999–2002, approximately 64% of heterosexually acquired HIV infections reported in the United States occurred in females. The proportion of infected females was highest among persons aged 13–19 years, consistent with a previous finding (5). Survey data suggest that females in this age group engage in behaviors that place them at increased risk for acquiring HIV infections; the high proportion of infected females might be associated with sexual contact with older males, who are more likely to be infected. In addition, young females might have more opportunities for HIV testing and diagnosis (e.g., routine family planning and gynecological services) than young males.

Persons in certain racial/ethnic populations continue to have disproportionate numbers of HIV infections. Non-Hispanic black and Hispanic populations constituted 21% of the total population of the 29 states in the study, according to the 2000 U.S. Census, yet these populations accounted for 84% of heterosexually acquired HIV infections during 1999–2002. HIV infections are concentrated in populations that traditionally have had limited access to prevention services, medical care, and effective therapies. Lack of knowledge about HIV, decreased perception of risk, use of drugs or alcohol, and different interpretations of so-called "safe sex" might

TABLE. Estimated* number and percentage of persons with new diagnosis of HIV infection, with and without AIDS, by selected characteristics — 29 states†, 1999–2002

	Heterosexually acquired HIV infections						Nonheterosexually acquired HIV infections		Total	
	Diagnosis without AIDS		Diagnosis with AIDS§		Total					
Characteristic	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex										
Male	9,656	(34)	3,223	(44)	**12,879**	**(36)**	59,129	(90)	**72,008**	**(71)**
Female	19,033	(66)	4,172	(56)	**23,205**	**(64)**	6,661	(10)	**29,866**	**(29)**
Age group (yrs)										
13–19	1,511	(5)	86	(1)	**1,597**	**(4)**	1,340	(2)	**2,937**	**(3)**
20–29	7,524	(26)	977	(13)	**8,501**	**(24)**	12,258	(19)	**20,759**	**(20)**
30–39	9,814	(34)	2,624	(36)	**12,438**	**(35)**	25,625	(39)	**38,063**	**(37)**
40–49	6,505	(23)	2,202	(30)	**8,707**	**(24)**	18,518	(28)	**27,225**	**(27)**
50–59	2,373	(8)	984	(13)	**3,357**	**(9)**	6,088	(9)	**9,445**	**(9)**
≥60	961	(3)	522	(7)	**1,483**	**(4)**	1,964	(3)	**3,447**	**(3)**
Race/Ethnicity										
White, non-Hispanic	4,072	(14)	1,185	(16)	**5,257**	**(15)**	26,731	(41)	**31,988**	**(31)**
Black, non-Hispanic	21,471	(75)	5,277	(71)	**26,748**	**(74)**	29,607	(45)	**56,355**	**(55)**
Hispanic¶	2,666	(9)	833	(11)	**3,498**	**(10)**	8,233	(12)	**11,731**	**(11)**
Asian/Pacific Islander	128	(<1)	48	(1)	**176**	**(<1)**	383	(1)	**559**	**(1)**
American Indian/ Alaska Native	134	(<1)	35	(<1)	**169**	**(<1)**	439	(1)	**608**	**(1)**
Unknown	218	(1)	18	(<1)	**236**	**(1)**	400	(1)	**636**	**(1)**
Year of diagnosis										
1999	7,016	(24)	1,909	(26)	**8,925**	**(25)**	16,023	(24)	**24,948**	**(24)**
2000	7,075	(25)	1,934	(26)	**9,009**	**(25)**	16,289	(25)	**25,298**	**(25)**
2001	7,227	(25)	1,767	(24)	**8,994**	**(25)**	16,393	(25)	**25,387**	**(25)**
2002	7,371	(26)	1,786	(24)	**9,156**	**(25)**	17,087	(26)	**26,243**	**(26)**
Total**	**28,689**	**(100)**	**7,395**	**(100)**	**36,084**	**(100)**	**65,793††**	**(100)**	**101,877**	**(100)**

* All estimates were adjusted for reporting delays and for reclassification of cases initially reported with no mode of exposure.
† Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
§ AIDS was diagnosed within the same calendar month of HIV diagnosis.
¶ Persons of Hispanic origin might be of any race.
** Because of rounding, the percentages in each column might not total 100%.
†† Includes three persons whose sex is unknown.

a•ware: *adj*

(ə-'wâr) 1 : marked by comprehension, cognizance, and perception; see also *MMWR*.

know what matters.

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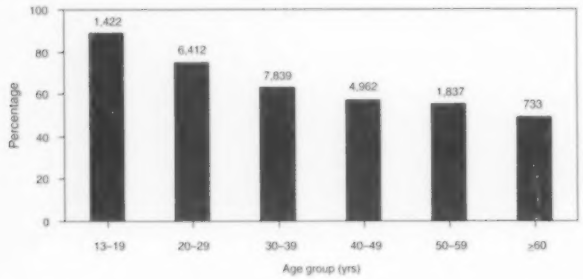
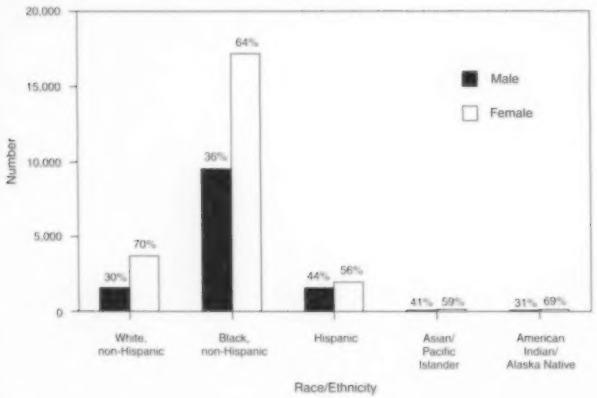
FIGURE 1. Number* of females aged ≥13 years with heterosexually acquired HIV infections, by age group and percentage of overall infected population — 29 states†, 1999–2002



*N = 23,205.
†Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

FIGURE 2. Number* and percentage of persons with heterosexually acquired HIV infections, by sex and race/ethnicity — 29 states†, 1999–2002



*N = 36,084.
†Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

contribute to the risk for HIV infection among non-Hispanic blacks and Hispanics (*6*). In addition, because of social patterns, non-Hispanic black and Hispanic females are more likely than other females to be exposed to HIV because of a higher prevalence of infection among non-Hispanic black and Hispanic males (*7*).

Diagnosis of HIV and AIDS in the same calendar month occurred with 20% of the heterosexually acquired HIV infections, reflecting HIV diagnosis late in the course of infection and suggesting late testing in the course of the disease. A previous study determined that 41% (43,089 of 104,780) of persons with reported HIV infections also received an AIDS diagnosis within 1 year, which might indicate treatment failure or late testing (*8*).

The findings in this report are subject to at least three limitations. First, although AIDS is a reportable condition in the United States, during 1999–2002, name-based HIV case data were available from only 29 states, which reported an estimated 39% of all AIDS cases. Nationwide reporting of HIV diagnoses would improve data regarding the HIV-infected population. Second, cases with no identified mode of exposure were classified into exposure categories on the basis of follow-up investigation. Cases with follow-up information were assumed to constitute a representative sample of all cases initially reported with no identified exposure, and the distribution among exposure categories was assumed to be consistent during the preceding 10 years. Finally, completeness of reporting and potential duplicate reporting by states are being evaluated in accordance with CDC's performance standards for HIV/AIDS surveillance (*2*). Reported HIV infections are estimated to represent >85% of all HIV infections (*9*).

CDC recommends reporting on the prevalence of HIV infection to detect patterns in HIV transmission. New testing technology that distinguishes between recent and long-term infections will allow for better characterization of HIV-transmission patterns and more rapid and targeted preventive measures (*10*). CDC is working in areas of high morbidity (i.e., >300 AIDS cases per year) to integrate this technology into routine HIV case surveillance.

Racial/ethnic disparities continue among persons with HIV infections. Culturally sensitive HIV-prevention messages are needed to target those populations most affected. Prevention and education programs targeting heterosexually active teens, especially females and persons in certain racial/ethnic populations, should be developed. In addition, non-Hispanic black and Hispanic populations, which historically have less access to treatment and prevention services, are affected disproportionately by HIV. Barriers to care and prevention services for these populations should be removed.

References

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). Report on the global HIV/AIDS epidemic, 2002. Geneva, Switzerland: World Health Organization, July 2002.

2. CDC. Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. MMWR 1999;48(No. RR-13).
3. Green T. Using surveillance data to monitor trends in the AIDS epidemic. Stat Med 1998;17:143–54.
4. Brookmeyer R, Liao J. The analysis of delays in disease reporting: methods and results for the acquired immunodeficiency syndrome. Am J Epidemiol 1990;132:355–65.
5. Lee LM, Fleming PL. Trends in human immunodeficiency virus diagnoses among women in the United States, 1994–1998. J Am Med Womens Assoc 2001;56:94–9.
6. Essien EJ, Meshack AF, Ross MW. Misperceptions about HIV transmission among heterosexual African-American and Latino men and women. J Natl Med Assoc 2002;94:304–12.
7. Kellerman S, Wortley P, Fleming P. The changing epidemic of HIV. Curr Infect Dis Rep 2000;2:457–65.
8. Neal JJ, Fleming PL. Frequency and predictors of late HIV diagnosis in the United States, 1994 through 1999 [Poster]. Presented at the 9th Conference on Retroviruses and Opportunistic Infections, Seattle, Washington, February 24–28, 2002.
9. CDC. HIV/AIDS Surveillance Report, 2002. Vol. 14. Available at http://www.cdc.gov/hiv/stats/hasrlink.htm.
10. CDC. Advancing HIV prevention: new strategies for a changing epidemic—United States, 2003. MMWR 2003;52:329–32.

Using the Internet for Partner Notification of Sexually Transmitted Diseases — Los Angeles County, California, 2003

An estimated one third of Internet visits by persons aged ≥18 years are to sexually oriented websites, chat rooms, and news groups that enable users to view sexual images or participate in online discussions of a sexual nature (*1*). Although so-called "virtual sex" carries no risk for transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), use of the Internet to find partners for actual sexual activity does carry such risk (*2*). During 2001–2003, of 759 men who have sex with men (MSM) and who had early syphilis, 172 (23%) reported using the Internet to meet sex partners (Los Angeles County Department of Health Services [LACDHS], unpublished data, 2003). Because the Internet enables sex partners to maintain anonymity by withholding identifying information (e.g., full name, address, and place of employment), it poses challenges for public health authorities (*3*). Use of the Internet by public health authorities to notify sex partners of persons with STDs has been reported previously (*2*). This report describes two cases in Los Angeles County (LAC), California, in which public health officials used the Internet to notify partners who were otherwise anonymous. Local public health authorities might develop similar strategies to use the Internet to reduce transmission of STDs.

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LACDHS reviewed disease intervention specialist (DIS) interview records to identify cases of online partner notification. Subsequent interviews with DIS personnel were conducted to determine the degree of partner follow-up and testing.

Case Reports

Case 1. In December 2002, an LAC resident aged 32 years visited his physician for a routine follow-up of his HIV infection, which was diagnosed in 1997. The patient had a rash and reported influenza-like symptoms 1 week before and subsequently tested positive for syphilis. In February 2003, LACDHS interviewed the patient by telephone about his sexual contacts. The patient reported 134 male sex partners, all of whom he met via the Internet during a 6-month period; 29 were repeat sex partners. He also stated that he never used condoms. The index patient provided 111 e-mail addresses and 23 telephone numbers to facilitate contact tracing and sex partner notification. First and last names were provided for eight contacts. LACDHS sent an e-mail message to all 111 sex partners, alerting them to an urgent health matter and requesting that they call the telephone number provided as soon as possible. The message concluded with a confidentiality notice. Of 111 persons who received e-mail messages, 29 (26%) persons responded and were contacted.

Case 2. In January 2003, an LAC resident aged 31 years sought medical attention at an emergency department after noticing a rash on his body. He received a diagnosis of scabies and was administered treatment; most of the rash resolved. However, a palmar/plantar rash persisted, and the patient tested positive for syphilis on March 3. In March, LACDHS interviewed the patient, who reported that he met 16 male sex partners over the Internet during his infectious period. He was asked to send his contacts an e-mail message about his infection. Subsequently, he provided LACDHS with 16 e-mail addresses and copies of 13 e-mail messages that he had sent to his sex partners, notifying them of their exposure to syphilis and the health department's efforts to contact them. Seven of the 13 persons replied and made arrangements to be tested for syphilis.

Reported by: *RM Pioquinto, EA Tupas, PR Kerndt, MD, STD Program, Los Angeles County Dept of Health Svcs, California. MM Taylor, MD, Div of STD Prevention; SD Holmberg, MD, Div of HIV Prevention, National Center for HIV, STD, and TB Prevention; PA Patel, MD, EIS Officer, CDC.*

Editorial Note: Partner notification is a process whereby sex partners of patients (index patients) who have an STD or HIV diagnosed are informed of their exposure to infection and the need to seek medical evaluation (*4*). The goals are to reduce the spread of STDs and HIV and to prevent reinfection of the index patient. Usually these goals are accomplished by provider referral or patient referral. Provider referral is a confidential process by which public health authorities request names and identifying information about sex partners from the index patient to notify those persons of their exposure. Patient referral is a process by which partners are notified by the index patient without the assistance of public health personnel. These methods have changed little since the 1960s.

As the cases described in this report indicate, the Internet presents new challenges and opportunities for STD and HIV prevention and control. Using the Internet to meet sex partners can be a sexual risk-taking behavior (*3,5*). Persons seeking testing at a municipal HIV-counseling and -testing site who sought Internet sex partners reported a high level of sexual risk-taking behavior; compared with non-Internet sex seekers, Internet sex seekers were more likely to be MSM and to have more previous STDs, more partners, more anal sex, and more sexual exposure to partners known to be HIV-positive (*3*). In a case involving seven persons with syphilis who met through an Internet chat room, the local health department worked with a marketing firm to enter the Internet chat room and send electronic messages to hundreds of users about the syphilis cluster (*5*). As a result, the local health department was able to notify and evaluate approximately 40% of named sex partners. A case-control study demonstrated a statistically significant association between Internet use and acquisition of syphilis in this population (*5*).

The cases described in this report indicate that public health departments can use the same technology that facilitates dissemination of STDs to prevent and control STDs. In addition, case 2 indicates that involvement of the index patient in partner notification via e-mail can improve partner response rates. In a separate evaluation of instant messaging (i.e., messages sent to a person logged into a chat room), nearly 50% of all persons contacted via this method by the health department responded and were evaluated for syphilis (K. Myers, LACDHS, personal communication, 2003).

Further study is needed to determine the most effective method of using the Internet as a means of partner notification and evaluation. However, personalized messages, messages sent from an e-mail provider or within an Internet service provider (ISP), and message headers referencing a health matter might be more likely to be read than general messages that are not personalized or do not reference a specific health matter (K. Myers, LACDHS, personal communication, 2003). The same confidentiality rules apply to messages sent online

as to those sent via telephone or mail; for this reason, discreet, urgent messages are most effective. Although online referral makes ensuring the confidentiality of the contact more difficult, it is an efficient method for establishing initial contact with an otherwise inaccessible person and allows subsequent communication to occur.

Public health authorities should develop strategies to use the Internet to reduce transmission of STDs. Suggested practices for online partner notification have been published (*2*). Other strategies include 1) providing health education and prevention messages on websites that are frequently visited by MSM via pop-up ads and links to websites offering information on STD-testing sites, STDs, and partner referral; 2) making health educators available in chat rooms to answer health-related questions; and 3) offering online test-result reporting, which might increase testing for HIV and STDs by preserving anonymity and decreasing the lag period from test to result.

References

1. Toomey KE, Rothenberg RB. Sex and cyberspace—virtual networks leading to high-risk sex. JAMA 2000;284:485–7.
2. CDC. Internet use and early syphilis infection among men who have sex with men—San Francisco, California, 1999–2003. MMWR 2003;52:1229–32.
3. McFarlene M, Bull SS, Rietmeijer CA. The Internet as a newly emerging risk environment for sexually transmitted diseases. JAMA 2000; 284:443–6.
4. Mathews C, Coetzee N, Zwarenstein M, et al. A systematic review of strategies for partner notification for sexually transmitted diseases, including HIV/AIDS. Intl J STD AIDS 2002;13:285–300.
5. Klausner JD, Wolf W, Fischer-Ponce L, Zolt I, Katz MH. Tracing a syphilis outbreak through cyberspace. JAMA 2000;284:447–9.

Fatal Case of Unsuspected Pertussis Diagnosed from a Blood Culture — Minnesota, 2003

Pertussis (i.e., whooping cough) is a prolonged cough illness caused by the bacteria *Bordetella pertussis* and associated typically with an inspiratory "whoop," paroxysmal cough, and posttussive vomiting. *B. pertussis* can cause severe illness or death, especially in infants who have not completed their pertussis vaccination series. Adolescents (i.e., persons aged 13–17 years), adults, and recently vaccinated persons often report atypical symptoms, resulting in delay of recognition and creation of infectious reservoirs for further transmission. In 2003, the Minnesota Department of Health (MDH) investigated a fatal case of unsuspected *B. pertussis* infection in an elderly adult. This report summarizes the case investigation, which documents the rare isolation of *B. pertussis* from blood and underscores the need for clinicians to consider pertussis infection in adolescents and adults who have a prolonged cough illness.

In February 2003, a woman aged 82 years on immunosuppressive medications for multiple myeloma was admitted to a local hospital for control of pain from vertebral compression fractures. A chest radiograph revealed a nodular infiltrate, which was thought to be a residual finding from pneumonia diagnosed in early January. Two days after hospitalization, the patient had a cough; rales were observed on lung examination. She remained afebrile and was discharged to a nursing care facility. The patient's cough worsened; she had a fever of 102.2° F (39° C) and labored respirations that required rehospitalization and mechanical ventilation. On readmission, a chest radiograph revealed diffuse left-lung infiltrates. She was placed on multiple nonmacrolide broad spectrum antibiotics but had hypotension and a sepsis-like syndrome. Respiratory support was withdrawn, and the patient died.

During her rehospitalization, tests for *Legionella* spp. and influenza A and B were negative. Gram stain of tracheal secretions showed gram-negative bacilli and white blood cells; the culture was negative. Blood cultures revealed gram-negative bacilli, but further identification of the pathogen by routine culture media was unsuccessful. *B. pertussis* was identified after a special culture medium containing charcoal and sheep blood was used. Because infection with *B. pertussis* was not suspected originally, no nasopharyngeal (NP) specimen was obtained for *B. pertussis* isolation.

The patient had lived with her daughter, a high-school nurse, who reported having an intermittent, nonproductive cough for approximately 1 month preceding her mother's illness. Her cough changed to a pertussis-like, paroxysmal cough approximately the same time as her mother's cough onset. By the time the patient's *B. pertussis* results were known, the daughter was asymptomatic and therefore was not tested. She reported no contact with students with pertussis-like symptoms.

A contact investigation identified 47 persons who were exposed to the index patient. Exposure was defined as ≥10 hours per week of close (i.e., <3 feet or "arms length") contact with the patient while she was symptomatic or direct face-to-face contact during an episode of coughing or sneezing, regardless of duration. NP specimens were obtained from exposed persons if they reported having a cough illness ≤20 days after their last exposure to the patient. Two (12%) of 17 exposed family members reported cough illness and had NP specimens tested; one tested positive for *B. pertussis* by culture and polymerase chain reaction (PCR). Ten (34%) of 29 exposed nursing home staff reported cough illness and were

tested; one (10%) person tested positive by culture and PCR. Hospital personnel were asked if they had exposure consistent with the definition; one physician reported mild upper-respiratory symptoms and was tested, but his NP specimen was lost. The epidemiologic link between the patient and both infected contacts was confirmed by pulsed-field gel electrophoresis (PFGE) analysis of isolates at MDH and CDC.

Reported by: *C Kenyon, MPH, C Miller, MS, K Ehresmann, MPH, Immunization, Tuberculosis, and International Health Section; D Boxrud, MS, Public Health Laboratory, Minnesota Dept of Health. P Cassiday, MS, GN Sanden, PhD, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; KM Bisgard, DVM, National Immunization Program; K Kiang, MD, EIS Officer, CDC.*

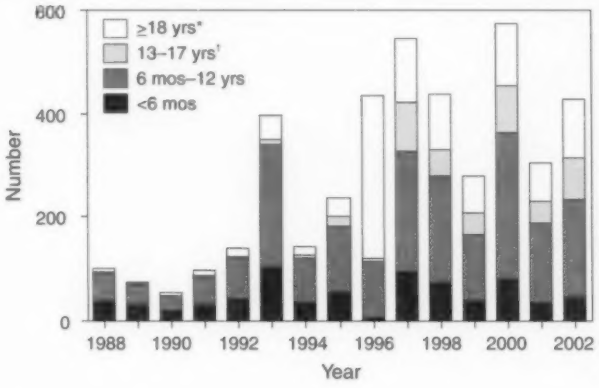
Editorial Note: The case described in this report is an example of a fatal case of unsuspected *B. pertussis* infection in an adult and the rare occurrence of *B. pertussis* isolated from blood. This is the second reported case of *B. pertussis* isolated from blood; this organism does not generally invade the bloodstream. *B. pertussis* also is difficult to recover through routine culture including NP specimens because of growth inhibitors encountered in standard culture medium. A special culture medium that contains activated charcoal (e.g., Regan-Lowe agar) or potato-derived starch (i.e., Bordet-Gengou agar) and defibrinated horse or sheep blood to neutralize the inhibitory substances must be used to isolate *B. pertussis* (*1*). Testing is not performed for *B. pertussis* unless a specific request is made.

Molecular epidemiologic techniques (e.g., PFGE) have enhanced surveillance for pertussis by helping to identify infection, track transmission in outbreaks, and describe geographic and temporal trends. In this investigation, the epidemiologic link between the index patient and contacts was confirmed by PFGE analysis of bacterial isolates.

Adolescents and adults account for a substantial proportion of pertussis cases (*2–4*). In Minnesota during 1997–2000, adolescents accounted for 15% of cases reported annually (18.3 per 100,000 population), and adults accounted for 23% of cases (3.1 per 100,000 population) (MDH, unpublished data, 1997–2000). The incidence of pertussis reported in adolescents and adults has increased markedly in Minnesota (Figure) and throughout the United States. This increase might be attributable in part to heightened awareness and improved detection of pertussis, with the introduction of PCR as a diagnostic tool.

Adolescents and adults who have pertussis are potential sources of infection for infants, who are most at risk for severe illness and death (*2,5–7*). During 1997–2001, three pertussis-associated deaths were reported in Minnesota; all occurred among infants aged <2 months. When a source of infection for infants is identified, household contacts are the most common source (*2,7*). In Minnesota during 1998–2001, the probable source of exposure to pertussis was determined in 50% of cases in infants aged <1 year; 67% of the source-patients were either adolescents (6%) or adults (61%). Because *B. pertussis* infection is a common cause of cough illness among adolescents and adults, heightened clinical suspicion for pertussis and appropriate testing of these persons is warranted.

FIGURE. Number of persons with pertussis, by year and age group — Minnesota, 1988–2002



* Adults.
† Adolescents.

Acknowledgments

This report is based on data contributed by V Miller, C Nassif, Mayo Clinic, Rochester; L Rahn, Chatfield, Minnesota.

References

1. Janda WM, Santos E, Stevens J, Celig D, Terrile L, Schreckenberger PC. Unexpected isolation of *Bordetella pertussis* from a blood culture. J Clin Microbiol 1994;32:2851–3.
2. CDC. Pertussis—United States, 1997–2002. MMWR 2002;51:73–6.
3. CDC. Pertussis outbreak among adults at an oil refinery—Illinois, August–October 2002. MMWR 2003;52:1–4.
4. Strebel P, Nordin J, Edwards K, et al. Population-based incidence of pertussis among adolescents and adults, Minnesota, 1995–1996. J Infect Dis 2001;183:1353–9.
5. CDC. Pertussis deaths—United States, 2000. MMWR 2001;51:616–8.
6. Vitek CR, Pascual FB, Baughman AL, Murphy TV. Increase in deaths from pertussis among young infants in the United States in the 1990s. Ped Infect Dis J 2003;22:628–34.
7. Bisgard KM, Cianfrini C, Pascual FB, et al. Infant pertussis: who is the source? Prospective investigation of cases from Georgia, Illinois, Massachusetts, Minnesota—January 1999–October 2000 [Abstract]. Baltimore, Maryland: Pediatric Academic Societies' Annual Meeting, April 28–May 1, 2001.

Notice to Readers

Release of Interactive Atlas of Reproductive Health

CDC has released the Interactive Atlas of Reproductive Health. This online public resource uses interactive geographic information systems (GIS) technology to generate state, urban, and county maps and tables displaying reproductive data that public health authorities can use to design prevention policies and programs to meet community needs. Six reproductive health indicator groups are available for analysis: fetal and infant mortality, pregnancy outcomes, maternal risks, teen risks, infant health, and maternal interventions. These indicators can be displayed as maps or tables by time, geographic level (state, county, or metropolitan statistical area), geographic view (national, regional, or state), and different demographic and risk categories. An estimated six million displays can be generated.

The atlas has two major sections: 1) interactive pages that provide an extensive series of national, regional, and state maps and tables of reproductive health indicator rates by selected demographic and risk groups in the United States and territories, and 2) help pages that explain GIS, define the indicators and the demographic and risk options, and explain how to use the interactive portion of the site.

The atlas is available at http://www.cdc.gov/reproductivehealth/gisatlas. Additional information about reproductive health is available at http://www.cdc.gov/reproductivehealth.

Errata: Vol. 53, No. 5

In the report, "Update: Adverse Events Following Civilian Smallpox Vaccination—United States, 2003," on page 107, the page numbers in reference 3 were incorrect. The correct reference should read, "CDC. Secondary and tertiary transfer of vaccinia virus among U.S. military personnel—United States and worldwide, 2002–2004. MMWR 2004;53:103–5."

In the report, "Global Polio Eradication Initiative Strategic Plan, 2004," on page 109, an error occurred in the address of the website listed in the last sentence of the last paragraph. The correct website address is http://www.polioeradication.org/all/news/document.asp.

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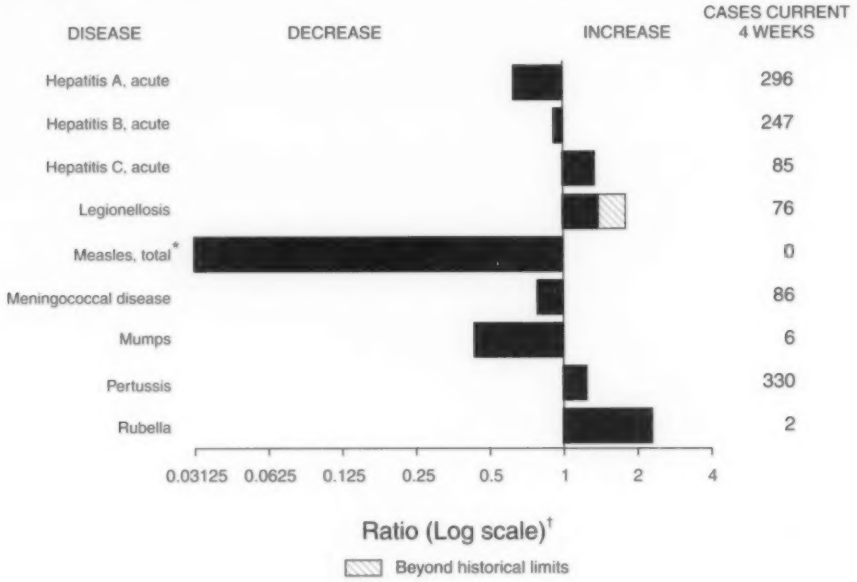
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 14, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 6 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 14, 2004 (6th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	4	18
Botulism:	-	-	HIV infection, pediatric†§	-	27
foodborne	2	1	Measles, total	2¶	1**
infant	5	10	Mumps	14	27
other (wound & unspecified	3	1	Plague	-	-
Brucellosis†	4	19	Poliomyelitis, paralytic	-	-
Chancroid	3	4	Psittacosis†	-	5
Cholera	1	-	Q fever†	3	13
Cyclosporiasis†	3	18	Rabies, human	-	-
Diphtheria	-	-	Rubella	3	-
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	-
human granulocytic (HGE)†	3	11	SARS-associated coronavirus disease† ††	-	-
human monocytic (HME)†	3	17	Smallpox† §§	-	NA
human, other and unspecified	-	1	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† §§	2	NA
California serogroup viral†	-	-	Vancomycin-resistant (VRSA)† §§	-	NA
eastern equine†	-	2	Streptococcal toxic-shock syndrome†	12	22
Powassan†	-	-	Tetanus	-	4
St. Louis†	1	2	Toxic-shock syndrome	14	6
western equine†	-	-	Trichinosis	1	-
Hansen disease (leprosy)†	5	16	Tularemia†	2	3
Hantavirus pulmonary syndrome†	2	4	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 28, 2003.
¶ Of two cases reported, one was indigenous, and one was imported from another country.
** Of one case reported, one was indigenous, and none were imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
§§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	-	5,274	69,790	90,967	222	421	213	308	3	57
NEW ENGLAND	-	192	2,522	3,191	-	-	7	13	-	-
Maine	-	-	102	206	N	N	2	1	-	-
N.H.	-	3	-	180	-	-	-	-	-	-
Vt.	-	5	71	128	-	-	2	1	-	-
Mass.	-	111	1,702	1,232	-	-	3	9	-	-
R.I.	-	16	494	325	-	-	-	1	-	-
Conn.	-	57	153	1,120	N	N	-	1	-	-
MID. ATLANTIC	-	1,541	9,010	12,014	-	-	35	24	1	-
Upstate N.Y.	-	77	1,688	1,180	N	N	9	4	-	-
N.Y. City	-	942	3,206	3,980	-	-	6	10	-	-
N.J.	-	170	1,289	1,925	-	-	1	2	-	-
Pa.	-	352	2,827	4,929	N	N	19	8	1	-
E.N. CENTRAL	-	632	10,057	17,920	-	1	40	38	-	-
Ohio	-	95	715	4,892	-	-	17	7	-	-
Ind.	-	84	1,429	2,047	N	N	2	1	-	-
Ill.	-	290	2,301	5,831	-	-	-	8	-	-
Mich.	-	143	4,353	3,171	-	1	13	5	-	-
Wis.	-	20	1,259	1,979	-	-	8	17	-	-
W.N. CENTRAL	-	60	3,484	5,093	-	-	20	13	-	-
Minn.	-	9	265	1,245	N	N	3	5	-	-
Iowa	-	17	-	306	N	N	1	3	-	-
Mo.	-	25	1,620	1,939	-	-	7	2	-	-
N. Dak.	-	-	90	92	N	N	-	-	-	-
S. Dak.	-	1	249	274	-	-	4	3	-	-
Nebr.¶	-	-	444	396	-	-	-	-	-	-
Kans.	-	8	816	841	N	N	5	-	-	-
S. ATLANTIC	-	1,118	11,551	14,384	-	-	43	149	1	57
Del.	-	30	337	333	N	N	-	1	-	-
Md.	-	103	1,993	1,794	-	-	5	5	-	-
D.C.	-	179	262	386	-	-	-	-	-	-
Va.	-	176	992	1,408	-	-	3	-	-	-
W. Va.	-	6	308	279	N	N	-	-	-	-
N.C.	-	123	1,951	2,120	N	N	13	3	-	-
S.C.¶	-	45	1,805	1,305	-	-	-	1	-	-
Ga.	-	309	332	2,521	-	-	9	10	-	-
Fla.	-	147	3,571	4,238	N	N	13	129	1	57
E.S. CENTRAL	-	80	5,117	6,062	N	N	13	11	-	-
Ky.	-	28	594	964	N	N	5	1	-	-
Tenn.	-	21	2,000	1,816	N	N	5	5	-	-
Ala.	-	12	1,268	1,739	-	-	2	4	-	-
Miss.	-	19	1,255	1,543	N	N	1	1	-	-
W.S. CENTRAL	-	698	11,531	11,555	-	-	12	5	1	-
Ark.	-	14	791	679	-	-	6	1	-	-
La.	-	15	3,496	2,088	N	N	-	-	1	-
Okla.	-	16	837	823	N	N	5	1	-	-
Tex.	-	653	6,407	7,965	-	-	1	3	-	-
MOUNTAIN	-	204	3,750	5,556	71	347	11	7	-	-
Mont.	-	7	27	237	N	N	-	-	-	-
Idaho	-	1	413	173	N	N	-	4	-	-
Wyo.	-	1	113	138	-	-	1	-	-	-
Colo.	-	23	330	1,474	N	N	6	2	-	-
N. Mex.	-	14	31	763	1	-	-	-	-	-
Ariz.	-	112	2,512	1,822	59	343	3	1	-	-
Utah	-	6	324	260	4	1	-	-	-	-
Nev.	-	40	-	689	7	3	1	-	-	-
PACIFIC	-	749	12,768	15,192	151	73	32	48	-	-
Wash.	-	72	1,819	1,655	N	N	-	-	-	-
Oreg.	-	47	810	514	-	-	3	2	-	-
Calif.	-	618	9,805	12,006	151	73	29	46	-	-
Alaska	-	6	323	404	-	-	-	-	-	-
Hawaii	-	6	11	613	-	-	-	-	-	-
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	-	145	135	27	N	N	N	N	-	-
V.I.	-	2	-	36	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 28, 2003.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	95	146	15	38	11	17	1,254	2,729	25,248	37,378
NEW ENGLAND	2	8	1	-	2	1	82	97	600	908
Maine	-	-	-	-	-	-	13	12	17	15
N.H.	-	2	-	-	-	-	-	5	-	15
Vt.	-	-	-	-	-	-	5	9	4	14
Mass.	-	3	-	-	2	1	61	67	417	361
R.I.	-	-	-	-	-	-	3	4	116	121
Conn.	2	3	1	-	-	-	-	-	46	382
MID. ATLANTIC	8	13	-	-	2	2	257	339	3,054	5,212
Upstate N.Y.	2	2	-	-	1	-	68	49	651	601
N.Y. City	2	1	-	-	-	-	79	136	1,055	1,633
N.J.	-	3	-	-	1	-	19	53	493	1,214
Pa.	4	7	-	-	-	2	91	101	855	1,764
E.N. CENTRAL	22	28	2	2	1	1	175	328	3,833	8,600
Ohio	11	4	-	-	1	1	95	112	353	2,632
Ind.	2	1	-	-	-	-	-	-	565	806
Ill.	1	6	-	-	-	-	13	96	892	2,721
Mich.	5	6	-	-	-	-	50	81	1,656	1,718
Wis.	3	11	2	2	-	-	17	39	367	723
W.N. CENTRAL	14	15	4	3	6	2	99	179	1,188	1,877
Minn.	6	7	-	3	-	-	26	33	89	351
Iowa	-	1	-	-	-	-	22	30	-	41
Mo.	5	3	4	-	1	-	32	66	639	1,032
N. Dak.	-	-	-	-	3	1	2	4	4	4
S. Dak.	-	1	-	-	-	-	4	7	23	15
Nebr.	1	3	-	-	-	-	5	19	123	120
Kans.	2	-	-	-	2	1	8	20	310	314
S. ATLANTIC	6	49	5	28	-	10	214	1,302	5,613	8,054
Del.	-	-	N	N	N	N	6	6	122	169
Md.	2	-	-	-	-	-	12	14	941	940
D.C.	-	-	-	-	-	-	4	-	186	316
Va.	-	1	1	-	-	-	22	13	374	761
W. Va.	-	-	-	-	-	-	1	-	100	95
N.C.	-	-	3	3	-	-	N	N	1,144	1,639
S.C.	-	-	-	-	-	-	1	4	917	753
Ga.	1	1	-	-	-	-	55	130	246	1,342
Fla.	3	47	1	25	-	10	113	1,135	1,583	2,039
E.S. CENTRAL	2	6	1	-	-	-	21	37	2,510	3,254
Ky.	-	-	1	-	-	-	N	N	272	445
Tenn.	-	4	-	-	-	-	12	16	801	914
Ala.	1	2	-	-	-	-	9	21	753	1,114
Miss.	1	-	-	-	-	-	-	-	684	781
W.S. CENTRAL	2	4	-	2	-	1	29	22	4,522	4,871
Ark.	-	1	-	-	-	-	15	15	381	449
La.	-	-	-	-	-	-	3	-	1,658	1,155
Okla.	2	-	-	-	-	-	11	7	390	348
Tex.	-	3	-	2	-	1	-	-	2,093	2,919
MOUNTAIN	19	7	1	2	-	-	139	137	1,029	1,270
Mont.	1	-	-	-	-	-	5	2	8	18
Idaho	2	3	-	1	-	-	22	21	9	8
Wyo.	-	-	-	-	-	-	1	3	5	8
Colo.	5	2	1	-	-	-	25	43	261	391
N. Mex.	-	-	-	1	-	-	3	8	4	130
Ariz.	7	1	N	N	N	N	49	32	711	490
Utah	2	1	-	-	-	-	25	15	31	31
Nev.	2	-	-	-	-	-	9	13	-	194
PACIFIC	20	16	1	1	-	-	238	288	2,899	3,332
Wash.	3	4	-	-	-	-	20	9	331	322
Oreg.	4	1	1	1	-	-	40	35	105	88
Calif.	10	11	-	-	-	-	168	222	2,407	2,726
Alaska	-	-	-	-	-	-	5	9	55	70
Hawaii	3	-	-	-	-	-	5	13	1	126
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	6	10	5
V.I.	-	-	-	-	-	-	-	-	-	8
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	187	284	2	5	12	12	18	29	532	1,005
NEW ENGLAND	11	18	-	-	1	1	-	1	97	19
Maine	1	-	-	-	-	-	-	-	4	1
N.H.	-	3	-	-	-	-	-	-	-	-
Vt.	1	4	-	-	-	-	-	-	4	1
Mass.	2	8	-	-	-	1	-	1	77	12
R.I.	1	-	-	-	-	-	-	-	-	-
Conn.	6	3	-	-	1	-	-	-	12	5
MID. ATLANTIC	38	28	-	-	-	-	5	3	70	112
Upstate N.Y.	15	3	-	-	-	-	1	1	6	5
N.Y. City	3	9	-	-	-	-	1	2	23	51
N.J.	5	5	-	-	-	-	1	-	9	18
Pa.	15	11	-	-	-	-	2	-	32	38
E.N. CENTRAL	31	26	-	1	6	1	4	7	39	82
Ohio	20	5	-	-	2	-	3	2	7	14
Ind.	1	1	-	-	-	-	1	-	3	2
Ill.	-	13	-	-	-	-	-	5	7	31
Mich.	7	4	-	1	4	1	-	-	20	24
Wis.	3	3	-	-	-	-	-	-	2	11
W.N. CENTRAL	5	14	-	-	1	-	-	3	14	17
Minn.	3	4	-	-	1	-	-	-	-	1
Iowa	-	-	-	-	-	-	-	-	4	5
Mo.	1	8	-	-	-	-	-	3	5	5
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	1	-	-	-	-	-	-	-	1	2
Kans.	-	2	-	-	-	-	-	-	4	4
S. ATLANTIC	57	140	-	1	-	8	4	9	112	525
Del.	-	-	-	-	-	-	-	-	-	2
Md.	16	8	-	-	-	1	1	-	22	19
D.C.	-	-	-	-	-	-	-	-	1	-
Va.	7	2	-	-	-	-	-	-	13	4
W. Va.	1	-	-	-	-	-	-	-	-	2
N.C.	1	2	-	-	-	-	-	-	5	5
S.C.	-	1	-	-	-	-	-	-	-	6
Ga.	19	4	-	-	-	-	2	-	35	76
Fla.	13	123	-	1	-	7	1	9	36	411
E.S. CENTRAL	10	15	-	-	-	-	1	3	11	19
Ky.	-	1	-	-	-	-	-	-	-	2
Tenn.	5	6	-	-	-	-	-	2	8	11
Ala.	5	7	-	-	-	-	1	1	-	5
Miss.	-	1	-	-	-	-	-	-	3	1
W.S. CENTRAL	4	10	-	-	1	1	-	-	9	56
Ark.	-	1	-	-	-	-	-	-	4	1
La.	-	4	-	-	-	-	-	-	-	6
Okla.	4	5	-	-	1	1	-	-	4	1
Tex.	-	-	-	-	-	-	-	-	1	48
MOUNTAIN	26	22	-	1	3	1	3	2	62	28
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	2	-
Wyo.	-	-	-	-	-	-	-	-	1	-
Colo.	3	4	-	-	-	-	1	-	1	1
N. Mex.	4	2	-	-	1	-	-	-	-	-
Ariz.	15	11	-	1	1	-	1	1	51	17
Utah	1	3	-	-	-	-	1	1	6	4
Nev.	3	2	-	-	1	1	-	-	1	6
PACIFIC	5	11	2	2	-	-	1	1	118	147
Wash.	3	-	2	-	-	-	1	-	5	2
Oreg.	2	5	-	-	-	-	-	1	9	12
Calif.	-	4	-	2	-	-	-	-	103	130
Alaska	-	-	-	-	-	-	-	-	-	1
Hawaii	-	2	-	-	-	-	-	-	1	2
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	-	3
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	Hepatitis (viral, acute), by type: B Cum. 2004	B Cum. 2003	C Cum. 2004	C Cum. 2003	Legionellosis Cum. 2004	Legionellosis Cum. 2003	Listeriosis Cum. 2004	Listeriosis Cum. 2003	Lyme disease Cum. 2004	Lyme disease Cum. 2003
UNITED STATES	453	1,363	165	335	124	264	41	80	477	879
NEW ENGLAND	18	30	-	-	1	4	1	2	5	36
Maine	-	-	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	1	-	-
Vt.	1	1	-	-	-	1	-	-	-	3
Mass.	17	19	-	-	-	2	-	1	1	33
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	-	10	U	U	1	1	1	-	4	-
MID. ATLANTIC	41	125	13	10	23	24	8	13	404	653
Upstate N.Y.	5	4	1	1	3	3	1	2	127	168
N.Y. City	1	55	-	-	-	5	1	4	-	-
N.J.	17	29	-	-	4	3	3	2	39	135
Pa.	18	37	12	9	16	13	3	5	238	350
E.N. CENTRAL	30	67	8	16	37	36	4	5	11	21
Ohio	20	23	1	1	26	16	3	1	11	4
Ind.	-	-	-	-	1	1	-	-	-	2
Ill.	-	-	-	3	-	8	-	3	-	-
Mich.	10	29	7	12	9	11	-	1	-	-
Wis.	-	15	-	-	1	-	1	-	U	15
W.N. CENTRAL	35	37	79	29	4	2	-	2	10	3
Minn.	2	2	-	-	-	-	-	1	3	-
Iowa	-	1	-	-	-	1	-	-	2	2
Mo.	32	30	79	29	3	-	-	-	3	1
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-
Nebr.	1	3	-	-	-	-	-	1	-	-
Kans.	-	1	-	-	-	1	-	-	2	-
S. ATLANTIC	167	820	28	85	31	168	13	42	37	133
Del.	1	1	-	-	1	-	N	N	-	14
Md.	12	11	2	2	5	9	2	1	28	32
D.C.	1	-	-	-	-	-	-	-	-	-
Va.	7	4	1	-	2	2	-	-	-	-
W. Va.	-	-	1	-	-	-	1	-	-	-
N.C.	23	16	1	1	5	2	3	1	5	6
S.C.	-	-	-	-	-	-	-	1	-	-
Ga.	48	152	5	3	5	4	4	1	-	1
Fla.	75	636	18	79	13	151	3	38	4	80
E.S. CENTRAL	27	40	25	11	4	1	1	3	-	6
Ky.	3	6	2	2	1	-	1	-	-	-
Tenn.	13	6	23	2	2	1	-	-	-	1
Ala.	2	13	-	1	1	-	-	2	-	-
Miss.	9	15	-	6	-	-	-	1	-	5
W.S. CENTRAL	5	89	5	173	2	14	-	3	-	14
Ark.	1	9	-	1	-	-	-	-	-	-
La.	4	17	4	23	-	-	-	-	-	2
Okla.	-	5	-	-	1	2	-	-	-	-
Tex.	-	58	1	149	1	12	-	3	-	12
MOUNTAIN	56	70	2	3	9	5	4	6	2	2
Mont.	-	2	-	-	-	-	-	1	-	-
Idaho	1	1	-	-	1	1	-	-	-	1
Wyo.	1	1	-	-	2	-	-	-	1	-
Colo.	7	8	-	2	1	-	-	3	-	-
N. Mex.	1	4	-	-	-	-	-	-	-	-
Ariz.	36	39	1	-	2	2	3	2	-	-
Utah	4	4	-	-	2	1	-	-	1	-
Nev.	6	11	1	1	1	1	1	-	-	1
PACIFIC	74	85	5	8	13	10	10	4	8	11
Wash.	6	2	1	-	2	-	2	-	1	-
Oreg.	13	16	1	2	N	N	3	-	1	3
Calif.	55	65	2	5	11	10	5	4	6	8
Alaska	-	-	-	-	-	-	-	-	-	-
Hawaii	-	2	1	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	1	9	-	-	-	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	94	197	209	268	718	700	238	568	51	49
NEW ENGLAND	8	6	6	10	235	90	19	49	4	-
Maine	-	1	-	1	-	-	1	3	-	-
N.H.	-	1	-	-	-	-	-	2	-	-
Vt.	-	-	1	-	5	14	3	3	-	-
Mass.	6	4	5	8	230	75	7	18	4	-
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	2	-	-	1	-	1	8	23	-	-
MID. ATLANTIC	13	24	24	23	203	59	33	73	3	5
Upstate N.Y.	4	4	6	2	142	23	33	26	-	-
N.Y. City	5	11	4	7	-	-	-	1	1	-
N.J.	-	3	2	2	15	13	-	18	-	4
Pa.	4	6	12	12	46	23	-	28	2	1
E.N. CENTRAL	8	12	31	24	99	53	1	4	-	1
Ohio	2	3	17	6	55	39	1	-	-	1
Ind.	-	-	2	4	-	-	-	2	-	-
Ill.	-	6	1	4	-	-	-	-	-	-
Mich.	3	2	9	6	12	4	-	2	-	-
Wis.	3	1	2	4	32	10	-	-	-	-
W.N. CENTRAL	8	4	10	11	38	18	32	58	1	1
Minn.	4	2	1	1	2	-	7	3	-	-
Iowa	1	2	2	4	6	4	8	5	-	1
Mo.	2	-	2	5	25	10	2	-	1	-
N. Dak.	-	-	-	-	-	-	5	8	-	-
S. Dak.	-	-	1	-	-	-	-	6	-	-
Nebr.	-	-	-	-	-	-	-	3	-	-
Kans.	1	-	4	1	5	4	10	33	-	-
S. ATLANTIC	36	112	37	121	28	157	114	344	39	39
Del.	-	-	-	4	2	-	1	-	-	-
Md.	12	11	4	3	12	11	13	29	3	5
D.C.	-	-	-	-	1	-	-	-	-	-
Va.	-	1	2	3	3	1	-	44	-	-
W. Va.	-	1	3	-	-	-	8	7	-	-
N.C.	1	4	3	3	-	17	55	54	35	16
S.C.	1	-	1	-	2	-	7	13	-	-
Ga.	4	3	6	1	-	14	30	35	1	-
Fla.	18	92	18	107	8	114	-	162	-	18
E.S. CENTRAL	1	2	7	10	11	15	9	12	3	1
Ky.	-	-	-	1	1	2	2	3	-	-
Tenn.	-	-	4	2	7	6	5	8	1	1
Ala.	1	2	1	3	1	7	2	1	1	-
Miss.	-	-	2	4	2	-	-	-	1	-
W.S. CENTRAL	4	11	22	28	2	-	12	9	-	2
Ark.	1	-	3	1	1	-	4	-	-	-
La.	2	1	7	9	1	-	-	-	-	-
Okla.	1	-	1	3	-	-	8	9	-	-
Tex.	-	10	11	15	-	-	-	-	-	2
MOUNTAIN	2	3	11	7	58	98	11	10	-	-
Mont.	-	-	1	-	4	-	-	1	-	-
Idaho	-	-	1	-	13	2	-	-	-	-
Wyo.	-	-	1	-	2	-	-	-	-	-
Colo.	-	2	4	-	30	36	-	-	-	-
N. Mex.	1	-	-	1	-	11	-	-	-	-
Ariz.	-	1	3	4	5	36	11	9	-	-
Utah	-	-	1	-	4	8	-	-	-	-
Nev.	1	-	-	2	-	5	-	-	-	-
PACIFIC	14	23	61	34	44	210	7	9	1	-
Wash.	2	3	3	2	27	5	-	-	-	-
Oreg.	1	5	11	7	16	26	-	-	-	-
Calif.	11	15	45	24	-	178	7	8	1	-
Alaska	-	-	-	-	1	-	-	1	-	-
Hawaii	-	-	2	1	-	1	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	1	-	-	7	3	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	2,295	7,286	886	4,809	485	844	359	803	32	58
NEW ENGLAND	101	101	26	39	19	51	-	14	-	-
Maine	4	5	-	2	1	-	-	-	-	-
N.H.	-	4	-	-	-	1	-	-	N	N
Vt.	3	3	-	-	-	2	-	2	-	-
Mass.	70	69	20	29	16	28	N	N	N	N
R.I.	4	4	-	2	2	-	-	-	-	-
Conn.	20	16	6	6	-	20	-	12	U	U
MID. ATLANTIC	228	364	100	213	57	114	20	14	7	10
Upstate N.Y.	45	36	39	17	22	29	7	5	3	8
N.Y. City	62	128	25	54	3	16	U	U	U	U
N.J.	35	76	17	59	8	25	N	N	N	N
Pa.	86	124	19	83	24	44	13	9	4	2
E.N. CENTRAL	310	448	77	183	87	158	88	53	19	34
Ohio	112	140	28	39	38	31	78	46	16	24
Ind.	17	19	3	7	1	6	10	7	3	1
Ill.	63	174	22	88	-	50	-	-	-	-
Mich.	68	60	15	27	45	52	N	N	N	N
Wis.	50	55	9	22	3	19	N	N	-	9
W.N. CENTRAL	143	150	37	85	28	37	27	35	3	6
Minn.	31	36	7	3	-	11	-	-	3	5
Iowa	29	40	2	2	N	N	N	N	N	N
Mo.	40	39	11	39	10	11	1	-	-	-
N. Dak.	4	2	1	-	3	1	-	1	-	1
S. Dak.	8	5	1	8	3	4	-	-	-	-
Nebr.	10	9	1	24	1	4	-	-	N	N
Kans.	21	19	14	9	11	6	26	34	N	N
S. ATLANTIC	685	5,183	290	3,498	157	285	198	658	1	-
Del.	1	7	1	51	-	1	-	-	N	N
Md.	51	70	17	101	26	25	-	1	-	-
D.C.	-	-	4	-	-	-	-	-	1	-
Va.	51	40	10	24	6	1	N	N	N	N
W. Va.	1	1	-	-	1	-	4	5	-	-
N.C.	102	150	24	111	11	17	N	N	U	U
S.C.	35	39	15	14	1	1	11	9	N	N
Ga.	140	207	61	348	83	9	97	32	N	N
Fla.	304	4,669	158	2,849	29	231	86	611	N	N
E.S. CENTRAL	120	197	36	96	19	10	11	10	-	-
Ky.	12	28	2	12	6	2	3	-	N	N
Tenn.	37	63	21	22	13	8	8	10	N	N
Ala.	49	69	10	45	-	-	-	-	N	N
Miss.	22	37	3	17	-	-	-	-	-	-
W.S. CENTRAL	65	246	64	307	22	68	8	16	2	7
Ark.	22	26	6	1	2	1	1	1	-	-
La.	7	37	10	48	-	-	7	15	1	1
Okla.	24	16	37	52	9	8	N	N	1	2
Tex.	12	167	11	206	11	59	N	N	-	4
MOUNTAIN	236	150	122	79	28	71	7	3	-	1
Mont.	7	4	1	-	-	-	-	-	-	-
Idaho	24	11	-	1	1	4	N	N	N	N
Wyo.	2	3	1	1	3	-	3	-	-	-
Colo.	26	58	10	19	9	18	-	-	-	-
N. Mex.	18	14	17	21	9	13	3	3	-	-
Ariz.	129	32	80	31	4	34	-	-	N	N
Utah	17	12	7	2	2	2	-	-	-	1
Nev.	13	16	6	4	-	-	1	-	-	-
PACIFIC	407	447	134	309	68	50	-	-	-	-
Wash.	25	26	5	2	-	-	-	-	N	N
Oreg.	31	23	7	8	N	N	N	N	N	N
Calif.	310	369	116	292	50	35	N	N	N	N
Alaska	16	12	-	2	-	-	-	-	N	N
Hawaii	25	17	6	5	18	15	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	5	44	1	-	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 14, 2004, and February 8, 2003 (6th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	550	771	21	63	452	754	15	40	1,196	2,001
NEW ENGLAND	8	14	-	-	17	18	2	1	120	408
Maine	-	-	-	-	-	-	-	-	6	225
N.H.	-	1	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-	114	145
Mass.	5	10	-	-	13	5	2	-	-	38
R.I.	2	1	-	-	3	3	-	-	-	-
Conn.	1	2	-	-	1	10	-	1	-	-
MID. ATLANTIC	69	87	3	9	129	169	-	5	6	2
Upstate N.Y.	5	2	1	1	-	9	-	-	-	-
N.Y. City	43	42	2	3	121	97	-	2	-	-
N.J.	15	27	-	5	-	23	-	3	-	-
Pa.	6	16	-	-	8	40	-	-	6	2
E.N. CENTRAL	52	116	10	14	96	59	1	4	608	994
Ohio	24	18	-	1	9	11	1	-	110	238
Ind.	7	4	-	5	13	13	-	2	-	-
Ill.	8	44	-	7	60	33	-	1	-	-
Mich.	10	48	10	1	8	-	-	1	466	621
Wis.	3	2	-	-	6	2	-	-	32	135
W.N. CENTRAL	10	28	-	-	40	35	-	-	24	2
Minn.	-	9	-	-	10	7	-	-	-	-
Iowa	-	1	-	-	-	3	-	-	N	N
Mo.	9	11	-	-	10	10	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	12	2
S. Dak.	-	-	-	-	-	4	-	-	12	-
Nebr.	1	-	-	-	-	-	-	-	-	-
Kans.	-	7	-	-	20	11	-	-	-	-
S. ATLANTIC	158	172	1	11	26	129	3	17	174	302
Del.	1	1	-	-	-	-	-	-	-	1
Md.	31	28	-	3	11	7	-	2	-	-
D.C.	10	3	-	-	-	-	-	-	4	-
Va.	1	9	-	1	-	7	1	-	-	55
W. Va.	-	-	-	-	2	1	-	-	163	241
N.C.	13	21	-	-	2	2	1	-	-	-
S.C.	15	9	-	3	11	10	-	-	7	5
Ga.	8	30	-	3	-	39	-	-	-	-
Fla.	79	71	1	1	-	63	1	15	-	-
E.S. CENTRAL	34	39	1	1	26	33	-	-	-	-
Ky.	7	7	-	-	-	-	-	-	-	-
Tenn.	17	17	1	1	15	8	-	-	-	-
Ala.	7	13	-	-	11	18	-	-	-	-
Miss.	3	2	-	-	-	7	-	-	-	-
W.S. CENTRAL	108	89	6	8	18	156	-	-	-	285
Ark.	7	8	-	-	6	5	-	-	-	-
La.	20	10	-	-	-	-	-	-	-	3
Okla.	4	5	-	-	12	7	-	-	-	-
Tex.	77	66	6	8	-	144	-	-	-	282
MOUNTAIN	40	32	-	12	21	14	2	2	264	8
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	4	-	-	-	-	-	-	-	-	-
Wyo.	1	-	-	-	-	1	-	-	10	2
Colo.	-	6	-	2	7	6	-	2	161	-
N. Mex.	-	8	-	4	-	-	-	-	6	-
Ariz.	34	16	-	6	9	7	-	-	-	-
Utah	1	1	-	-	5	-	1	-	87	6
Nev.	-	1	-	-	-	-	1	-	-	-
PACIFIC	71	194	-	8	79	141	7	11	-	-
Wash.	10	7	-	-	29	19	1	-	-	-
Oreg.	9	5	-	-	7	8	-	2	-	-
Calif.	52	181	-	8	29	94	5	9	-	-
Alaska	-	-	-	-	4	5	-	-	-	-
Hawaii	-	1	-	-	10	15	1	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	10	9	-	-	-	-	-	-	28	38
V.I.	-	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending February 14, 2004 (6th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	582	405	120	40	8	9	87
Boston, Mass.	168	117	33	13	3	2	17
Bridgeport, Conn.	28	22	5	1	-	-	4
Cambridge, Mass.	16	12	3	1	-	-	2
Fall River, Mass.	41	25	10	5	-	1	7
Hartford, Conn.	47	34	11	2	-	-	14
Lowell, Mass.	29	18	7	4	-	-	2
Lynn, Mass.	9	4	4	1	-	-	-
New Bedford, Mass.	37	29	6	2	-	-	1
New Haven, Conn.	30	22	6	1	-	1	8
Providence, R.I.	69	47	12	4	3	3	12
Somerville, Mass.	1	1	-	-	-	-	-
Springfield, Mass.	42	31	7	1	2	1	7
Waterbury, Conn.	25	16	4	5	-	-	6
Worcester, Mass.	40	27	12	-	-	1	7
MID. ATLANTIC	2,734	1,936	541	157	51	42	178
Albany, N.Y.	62	38	17	2	3	2	2
Allentown, Pa.	15	13	2	-	-	-	2
Buffalo, N.Y.	59	38	13	3	2	3	8
Camden, N.J.	26	16	8	1	-	1	2
Elizabeth, N.J.	12	5	6	-	1	-	2
Erie, Pa.	55	41	12	1	-	1	2
Jersey City, N.J.	58	44	10	3	-	1	-
New York City, N.Y.	1,566	1,124	298	88	27	23	108
Newark, N.J.	62	35	17	9	1	-	2
Paterson, N.J.	31	17	9	1	2	2	-
Philadelphia, Pa.	377	249	85	29	9	4	15
Pittsburgh, Pa.§	27	18	9	-	-	-	4
Reading, Pa.	25	24	1	-	-	-	2
Rochester, N.Y.	156	119	24	11	1	1	16
Schenectady, N.Y.	31	23	5	3	-	-	2
Scranton, Pa.	28	25	3	-	-	-	-
Syracuse, N.Y.	97	72	12	4	5	4	8
Trenton, N.J.	24	20	3	1	-	-	2
Utica, N.Y.	23	15	7	1	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,232	1,505	496	119	46	59	173
Akron, Ohio	U	U	U	U	U	U	U
Canton, Ohio	50	36	12	1	-	1	3
Chicago, Ill.	394	250	91	28	11	7	29
Cincinnati, Ohio	87	57	13	7	2	8	14
Cleveland, Ohio	215	153	38	12	4	8	14
Columbus, Ohio	278	199	55	18	2	4	34
Dayton, Ohio	175	134	29	7	3	2	14
Detroit, Mich.	227	118	83	15	6	5	8
Evansville, Ind.	49	36	10	2	1	-	7
Fort Wayne, Ind.	65	44	19	1	-	1	3
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	60	38	14	1	3	4	5
Indianapolis, Ind.	234	162	43	10	8	11	17
Lansing, Mich.	35	21	10	2	-	2	6
Milwaukee, Wis.	132	89	33	8	1	1	8
Peoria, Ill.	57	42	12	1	1	1	-
Rockford, Ill.	74	49	13	5	4	3	4
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	100	77	21	1	-	1	7
Youngstown, Ohio	U	U	U	U	U	U	U
W.N. CENTRAL	637	473	111	23	12	18	55
Des Moines, Iowa	70	54	10	4	1	1	9
Duluth, Minn.	38	31	3	3	-	1	-
Kansas City, Kans.	32	25	3	3	-	1	4
Kansas City, Mo.	105	74	24	2	2	3	9
Lincoln, Nebr.	61	51	8	1	-	1	4
Minneapolis, Minn.	80	54	16	4	4	2	9
Omaha, Nebr.	106	81	18	3	-	4	10
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	53	42	7	-	1	3	6
Wichita, Kans.	92	61	22	3	4	2	4
S. ATLANTIC	1,384	866	329	129	40	19	108
Atlanta, Ga.	183	102	47	25	9	-	14
Baltimore, Md.	229	129	66	23	8	3	23
Charlotte, N.C.	104	65	27	11	1	-	11
Jacksonville, Fla.	157	101	33	11	5	6	16
Miami, Fla.	128	91	17	17	3	-	9
Norfolk, Va.	58	36	12	5	4	1	3
Richmond, Va.	66	38	17	5	5	1	7
Savannah, Ga.	51	33	12	5	1	-	2
St. Petersburg, Fla.	81	66	11	3	1	-	7
Tampa, Fla.	209	136	53	11	2	7	13
Washington, D.C.	99	55	30	12	1	1	1
Wilmington, Del.	19	14	4	1	-	-	2
E.S. CENTRAL	941	656	190	57	25	12	93
Birmingham, Ala.	210	135	43	17	11	3	19
Chattanooga, Tenn.	99	77	17	4	1	-	9
Knoxville, Tenn.	112	87	19	5	1	-	2
Lexington, Ky.	41	28	9	2	2	-	8
Memphis, Tenn.	148	100	28	9	7	4	21
Mobile, Ala.	102	77	15	4	3	3	4
Montgomery, Ala.	62	44	14	4	-	-	6
Nashville, Tenn.	167	108	45	12	-	2	24
W.S. CENTRAL	1,637	1,058	366	123	47	43	118
Austin, Tex.	96	66	23	5	1	1	5
Baton Rouge, La.	35	19	11	4	1	-	-
Corpus Christi, Tex.	61	43	12	4	1	1	4
Dallas, Tex.	211	136	48	10	11	6	16
El Paso, Tex.	118	76	29	6	3	4	11
Ft. Worth, Tex.	130	76	27	12	7	8	9
Houston, Tex.	374	237	84	33	11	9	34
Little Rock, Ark.	93	59	20	9	3	2	-
New Orleans, La.	39	19	12	8	-	-	-
San Antonio, Tex.	327	212	73	27	6	9	29
Shreveport, La.	52	43	6	-	1	2	5
Tulsa, Okla.	101	72	21	5	2	1	5
MOUNTAIN	984	665	210	62	22	25	72
Albuquerque, N.M.	155	95	38	14	3	5	11
Boise, Idaho	64	42	16	2	3	1	3
Colo. Springs, Colo.	66	37	17	6	2	4	-
Denver, Colo.	113	92	13	5	2	1	10
Las Vegas, Nev.	264	170	67	18	3	6	21
Ogden, Utah	29	25	2	2	-	-	1
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	28	22	4	2	-	-	-
Salt Lake City, Utah	111	76	23	7	1	4	12
Tucson, Ariz.	154	106	30	6	8	4	14
PACIFIC	2,700	1,945	494	152	59	49	314
Berkeley, Calif.	18	9	8	-	-	1	4
Fresno, Calif.	103	67	23	8	3	2	8
Glendale, Calif.	82	60	18	3	1	-	10
Honolulu, Hawaii	97	70	18	3	4	2	12
Long Beach, Calif.	67	43	17	3	2	2	6
Los Angeles, Calif.	1,379	1,011	227	80	34	27	196
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	112	80	21	6	1	4	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	209	148	38	13	4	5	19
San Francisco, Calif.	114	87	17	9	1	-	13
San Jose, Calif.	216	155	42	11	3	5	18
Santa Cruz, Calif.	37	31	5	1	-	-	6
Seattle, Wash.	115	79	24	10	2	-	7
Spokane, Wash.	57	43	11	1	1	1	2
Tacoma, Wash.	94	62	25	4	3	-	5
TOTAL	13,831¶	9,509	2,857	862	310	276	1,198

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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☆U.S. Government Printing Office: 2004-633-140/69172 Region IV ISSN: 0149-2195

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